

All practice recommendations are from the **American Diabetes Association**.

Source: Executive Summary: Standards of Medical Care in Diabetes — 2009. *Diabetes Care* 2009;32:S6-S12.

Website: http://care.diabetesjournals.org/cgi/content/full/32/Supplement_1/S6

Strength of Evidence: The strength of evidence is indicated following each recommendation. See table below for description of evidence levels.

A1C Goals

Recommendation #1: Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1C goal for nonpregnant adults in general is <7%. (A)

Self-Monitoring of Blood Glucose

Recommendation #2: SMBG should be carried out three or more times daily for patients using multiple insulin injections or insulin pump therapy. (A)

Recommendation #3: For patients using less frequent insulin injections, noninsulin therapies, or medical nutrition therapy (MNT) and physical activity alone, SMBG may be useful as a guide to the success of therapy. (E)

Recommendation #4: To achieve postprandial glucose targets, postprandial SMBG may be appropriate. (E)

Hypertension

Recommendation #5: Patients with diabetes should be treated to a systolic blood pressure <130 mm Hg (C) and a diastolic <80 mm Hg. (B)

Recommendation #6: Patients with a systolic BP of 130–139 mm Hg or a diastolic blood pressure of 80–89 mm Hg may be given lifestyle therapy alone for a maximum of 3 months and then, if targets are not achieved, be treated with addition of pharmacological agents. (E)

Hypertension

Recommendation #7: Patients with more severe hypertension (systolic blood pressure 140 mm Hg or diastolic 90 mm Hg) at diagnosis or follow-up should receive pharmacologic therapy in addition to lifestyle therapy. (A)

Recommendation #8: Multiple drug therapy (two or more agents at maximal doses) is generally required to achieve BP targets. (B)

Recommendation #9: Pharmacologic therapy for patients with diabetes and hypertension should include an ACE inhibitor or ARB. If one class is not tolerated, the other should be substituted. If needed to achieve BP targets, a thiazide diuretic should be added to those with an estimated GFR ≥ 30 ml/min per 1.73 m² and a loop diuretic for those with an estimated GFR <30 ml/min per 1.73 m². (C)

Lipid Management

Recommendation #10: Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients with overt CVD (A) – or without CVD who are over age 40 years and one or more other CVD risk factors. (A)

Recommendation #11: For patients at lower risk than those above, statin therapy should be considered in addition to lifestyle therapy if LDL cholesterol remains above 100 mg/dL or in those with multiple CVD risk factors (E)

Recommendation #12: In individuals without overt CVD, the primary goal is an LDL cholesterol <100 mg/dL (2.6 mmol/L). (A)

Recommendation #13: In individuals with overt CVD, a lower LDL cholesterol goal of <70 mg/dL (1.8 mmol/L), using a high dose of a statin, is an option. (B)

Antiplatelet Agents

Recommendation #14: Use aspirin therapy (75–162 mg/day) as a primary prevention strategy in those with type 2 diabetes at increased cardiovascular risk, including those who are >40 years of age or who have additional risk factors (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria). (C)

Recommendation #15: Use aspirin therapy (75–162 mg/day) as a secondary prevention strategy in those with diabetes with a history of CVD. (A)

Microalbuminuria

Recommendation #16: Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of ≥ 5 years and in all type 2 diabetic patients, starting at diagnosis. (E)

Recommendation #17: Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. (E)

Definitions of the ADA's Level of Evidence

Level of evidence	Description
A	Clear evidence from well-conducted, generalizable, randomized controlled trials that are adequately powered, including: <ul style="list-style-type: none"> • Evidence from a well-conducted multicenter trial • Evidence from a meta-analysis that incorporated quality ratings in the analysis
	Compelling nonexperimental evidence, i.e., the “all or none” rule developed by the Centre for Evidence-Based Medicine at Oxford
	Supportive evidence from well-conducted randomized controlled trials that are adequately powered, including: <ul style="list-style-type: none"> • Evidence from a well-conducted trial at one or more institutions • Evidence from a meta-analysis that incorporated quality ratings in the analysis
B	Supportive evidence from well-conducted cohort studies, including: <ul style="list-style-type: none"> • Evidence from a well-conducted prospective cohort study or registry • Evidence from a well-conducted meta-analysis of cohort studies
	Supportive evidence from a well-conducted case-control study
C	Supportive evidence from poorly controlled or uncontrolled studies, including: <ul style="list-style-type: none"> • Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results • Evidence from observational studies with high potential for bias (such as case series with comparison to historical controls) • Evidence from case series or case reports
	Conflicting evidence with the weight of evidence supporting the recommendation
E	Expert consensus or clinical experience